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AN EXPERIMENT IN INSERVICE MENTAL HEALTH EDUCATION FOR PUBLIC HEALTH NURSES

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Previously published reports describe the evolution of a program of psychiatric consultation to health and welfare agencies[1] and details of the over-all mental health program of the Contra Costa County Health Department.[2] This paper describes the part public health nurses had in the program from its inception in 1948, with particular attention paid to the period since July 1954, when an inservice mental health education program was begun for the staff nurses.

The population of Contra Costa County is 375,000. The health department is situated in Martinez, the county seat. There are four district offices and two subdistrict offices in other parts of the county. A generalized public health nursing service is available to families throughout the county. School nursing is done primarily (95 percent) on a specialized basis by nurses employed by local school districts. Only schools without their own nurses are served by health department nurses. The public health nurses work closely with the school nurses when there are family health problems involving both.

In 1948 when the Contra Costa County mental health program began there was a staff of 20 nurses and no supervising nurses. By 1954 there were 41 public health staff nurses and six supervisors. This growth in size reflects that of the county population, which had trebled in size from 1940 to 1950.

This is a report of the educational aspect of public health nursing experience in the development of a mental health program in Contra Costa County, California.

The mental health program began with group meetings between the health department administrators and the psychiatrist from the County Hospital. The Director of Public Health Nursing was included in these. From the beginning, consultation service was available to the Director of Nursing concerning public health nursing services. As supervising nurses were added to the staff they became part of the administrative group meetings with the psychiatrist. In 1951, the psychiatrist began meeting with each supervisor and her staff nurse unit in the local district offices. Meetings were held one hour each month. Discussions usually centered about those family situations encountered by staff nurses in which the nurses felt their efforts were blocked. There were group analyses of patients' feelings and behavior as well as of nurses' reactions to patient behavior. A few sessions were devoted to didactic material such as psychosocial development, defense mechanism and the like.

These group meetings and meetings of the supervisors with the consultant psychiatrist have been continued ever since. Meanwhile one supervisor was given leave for graduate study in mental health and returned on completion of her study in 1954. When the position of Educational Assistant (to the Director of Nursing) was instituted in 1956, this supervisor took the position. It was agreed that one-third of her time would be devoted to mental health consultation activities—an arrangement which has continued to the time of this report. Her activities in this capacity have included staff group meetings and individual consultation to staff and supervisors. Some of these have been planned and some held on request. She has frequently helped the nurses to understand psychiatric concepts and terms introduced by the consultant psychiatrist and to apply them in their own role and function as public health nurses. Because of these activities in the program, the title mental health consultant will be used in this report even though it is not her "official" title.

Against this general background a more unique method of inservice mental health education will be described in some detail. It has proved to be successful in Contra Costa County. The method is to provide an experience for the nurses, in which they give long-term, intensive nursing care to selected patients whose illnesses are predominantly emotional.

In July 1954, public health nurses of the County Health Department began to accept, as part of their inserv-

[1] Wasserman, Franz, M.D. The Psychiatric Service of Contra Costa County. *California's Health*. May 15, 1958.

[2] Blum, H. L., M.D., M.P.H., and Ketterer, W.A., M.D., M.P.H. A Health Department's Activities in Mental Health. *Public Health Reports*, July, 1958.

ice education program, a few carefully selected patients about to be discharged from the county hospital psychiatric observation ward. All these persons had been brought to the hospital by relatives or friends concerned about their behavior. Some had attempted suicide; some were ashamed of their own actions or feelings; others were afraid of what they might do to themselves or their children. All but one were women. Each had been seen by a hospital psychiatrist for one or more diagnostic interviews in which an attempt had been made to help the patient to see a connection between symptoms and unresolved emotional conflicts. None was actively psychotic or required further hospitalization. Diagnoses were most frequently "anxiety neurosis" and "neurotic depression." Two were alcoholics. "Hysterical reaction" and "hypochondriasis" were included. The psychiatrist had discussed with each person the need for continuing care and the resources available in the county. These are: (1) private psychiatric care, (2) a State Mental Hygiene Clinic in an adjoining county (inadequately staffed and inaccessible to many), (3) social case work services limited to clients of the child welfare division of the county welfare department, and (4) the program of the county health department (referred to above) which provides home visits on a regular basis to give supportive care in a professional nurse-patient relationship.

If the patient chose the fourth resource mentioned and if the psychiatrist judged the patient's problem to be within the scope of a public health nurse's ability, referral was made to the health department. The chief nurse of the psychiatric ward transmitted the psychiatrist's notes, impressions and recommendations to the public health nursing mental health consultant. She in turn discussed the referral with the district public health nurse and her supervisor. Decision about accepting the referral was made on the basis of the patient's emotional problem, the nurse's feelings about this kind of problem and the nurse's ability to carry out the recommended service.

Almost half the patients referred during the first year had previously been acquainted with the nurses because of other health problems in their families. At no time was there any pressure on a nurse to accept such a patient for care. Two did refuse such referrals. In a few situations the supervisor or the mental health nursing consultant, or both, made the decision not to assign a patient to a particular nurse because of work load or probable incompatibility between the nurse and the patient. At first all the nurses were apprehensive about attempting this new kind of service but said they would try if they had "lots of help." A few have seen this as an excellent learning experience and have been eager from the start to learn more about helping patients with emotional problems. At no time has any one nurse carried more than two patients for this intensive care. Most have found that one such case is all a nurse can manage in addition to her regular case load.

Weekly nursing visits were planned when care was begun. The interval between visits was then gradually lengthened as indicated. The nurses say that "these cases are very tiring, but they are worth it."

The conference held at the county hospital before the patient is discharged has proved to be a most important part of the process. It provides a link or bridge betwen care in the hospital and care in the home. It seems to be needed by both patient and nurse. It establishes the traditional doctor-nurse-patient relationship which is readily understood and promotes acceptance of the arrangement. The discharge conference includes the medical and nursing personnel involved.

A variety of plans have been tried for conducting the discharge conference. At first the group included the public health nurse, her supervisor, the psychiatrist, the chief nurse of the psychiatric ward, and the nurse mental health consultant. The conference was held after the public health nurse and the patient had been introduced to each other by the chief psychiatric nurse on the hospital ward. This method had been instituted with the idea that it would provide a continuity of care from nurse to nurse. The first two experiences made it apparent that the nurse needed to learn more about the patient before making her first and most important contact. Otherwise she was unprepared for the patient's questions and felt "caught" or anxious. To correct this situation the conference was scheduled prior to the nurse's introduction to the patient. The chief nurse or the psychiatrist began by reporting events and patient behavior from the time of hospital admission to the present. If the public health nurse had any record of the patient she brought it to the conference and reported. The psychiatrist then told of his findings, his view of the patient's needs and problems and her strengths and weaknesses. He suggested ways in which the nurse might help the patient develop her strengths to better meet the patient's needs. The nurse was free to ask questions at any point during the discussion. She also expressed her own feelings about her own abilities and the patient's problem. The supervising nurse asked any questions she needed to help her own understanding of the situation in relation to the patient and to the nurse. The nurse mental health consultant frequently asked the psychiatrist to explain in greater detail to the nurse and the supervisor the kinds of behavior and situations the nurse might expect to encounter in this particular nurse-patient relationship and how she herself might react.

A third important development in the discharge conference was the inclusion of the patient. It proved to be helpful to the nurse to have opportunity to observe the psychiatrist-patient interaction. It also helped her to hear what they talked about.

The present form of the discharge conference is the result of these experiences. Now the psychiatrist, public health nurse, her supervisor, and the nurse mental health consultant meet in the hospital for case discussion. The presence of the hospital psychiatric nurse is optional. After the preliminary discussion the psychatrist goes to the ward and escorts the patient to the group. She is introduced to "her nurse" and is encouraged to tell about how she felt at the time of hospitalization, her present feelings, and what plans she has for herself after her return home. The psychiatrist helps her express her feelings. This short "demonstration interview" is considered the most helpful part of the arrangements. One nurse said "It gave me an idea of how to begin." Frequently the interview is transferred from psychiatrist to nurse and the conference ends with the nurse and patient planning for the beginning of the home visits. The nurse escorts the patient from the conference room, asks her to wait until she has talked with the doctor

again, and returns to the conference group where new questions which have occurred to her can be brought up. She then rejoins the patient where details about beginning of home visits are settled. By the end of the conference the nurse has become "the patient's nurse" in every sense and has assumed this role.

Subsequent psychiatric consultation about these cases has been available. Usually the nurse mental health consultant uses it to extend her own understanding of the patient's behavior and problems. Then she in turn can be more effective in helping the supervisor in her work with the nurse and the nurse in her work with the patient. In this way she can provide a quality of continuity to the consultation which helps the supervisor and the nurse to become more perceptive of the interacting processes of the case and thus become more skillful in constructive use of the nurse-patient relationship.

Occasionally a second conference has been held including the staff nurse, her supervisor, and the nurse mental health consultant, who together get help from the psychiatrist for clearer understanding of the patient's behavior and the nurse's role. Two patients were given a second interview by the psychiatrist for the purpose of evaluating progress of prescribing or renewing prescriptions for medication. These second patient interviews with the doctor seem to have given added impetus to patient improvement.

The case material collected illustrates step-by-step the nurse-patient involvement, setbacks, progress, interaction. The case records show that when the relationship actually becomes a therapeutic one, there is demonstrable improvement in the patient and her relationship with family members.

Lack of objective standards makes program evaluation difficult. On the basis of four years experience the conclusion has been reached that the nursing care provided on this long-time supportive basis is a significant factor in the patient's improvement, even though it is recognized as only one of many forces operating in a family situation. The criteria by which this judgment has been made are: increased ability of patients to develop behavior patterns more satisfying to themselves; concurrent improvement of behavior of other family members; diminishing dependence for support in the form of financial assistance, medical care, medications, or alcohol.

There is no doubt that the experience has been productive in heightening nurse awareness and increasing perception of emotional components of behavior. There have been several developments which have direct connection with the type of experience described as inservice education.

First: Another group of patients soon developed for whom the same type of long-term intensive care was needed. The staff began recognizing such persons in their regular case loads. Outpatient diagnostic services were then developed in the county hospital to meet the demand of county agency referrals.

The nurse then handled these cases in the same manner and with the same pattern of consultation as with the hospitalized patients.

Second: A third group of patients has been identified by the nurses as resembling the first two groups but differing in that they resist referral. These often are persons whose emotional difficulties and attitudes block desirable health practices. With the help of the nurse mental health consultant the nurses are learning to gain perspective which enables them to work more effectively with this type of patient. Sometimes the patient comes to accept referral for psychiatric care. A significant number show improvement with nursing care alone.

Third: Successful referrals to agencies have increased. A referral plan with the State Mental Hygiene Clinic now includes a discharge conference similar to that developed in the county hospital. Some patients referred to the state clinic receive limited treatment and are referred back to the public health nurse for supportive followup. The state clinic has also referred the families of some of their patients to the public health nurses for health problems other than emotional ones.

Fourth: There is increasing co-ordination and complementary service given to families known to the public health nurses and to state social workers responsible for followup after discharge from the state mental hospitals. The social workers are often not able to see the patients as frequently as is desirable, and the nurses, who see these families for other health reasons, can and do report any significant changes or developments to the social worker who has legal responsibility for the patient.

What has been accomplished reflects the attitudes and activities described in the two previous publications mentioned on page 1. Consultation from the county psychiatric consultation service has been given by six different psychiatrists during the four years detailed above. Through the relationship with them the entire nursing staff has developed a closer working knowledge of psychiatry as a field of medicine. Ability has developed among the nurses to examine and understand their own and their patient's behavior with less fear.

Without vision and leadership from the health department administration the program could not have been developed or maintained. It was the Health Officer's decision that the program of followup of selected county hospital patients be instituted. The Director of Nursing created the position in which the nurse mental health consultant functions. Time has been allocated for staff and supervisors to participate in this time-consuming activity without encroachment on the

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total nursing program. There has been administrative support for the development of methods which required constant exploration and revision.

The experience of working with emotionally disturbed persons with support and help from psychiatrist and nurse mental health consultant is now seen as an unusually valuable learning experience for most public health nurses. Moreover, it has resulted in nursing service to at least a segment of emotionally disturbed persons in Contra Costa County.

The nurses' utilization of new understanding is evidenced by the increased effectiveness of their work with persons in their regular case load. The levels of interest and extent of participation in such a program varied from nurse to nurse. The program has demanded much time and energy, but those involved feel that the results are worth it. Future efforts will be directed towards developing methods of intensification and consolidation of the more productive parts of the experience.

Prevention of Blindness Program Set Up In Department

After a five-year study of the distribution and nature of conditions leading to blindness among the people of California, a prevention of blindness program has been established in the department.

Made possible by the passage of Senate Bill No. 547, the program is a direct result and in many ways a continuation of the Prevention of Blindness Project begun in 1954. Financed by the W. K. Kellogg Foundation, this project was inaugurated for the primary purpose of investigating the practicability of public health programs for the prevention of blindness in California. In addition to investigating the causes and distribution of blindness, the project demonstrated that much blindness can be prevented through activities such as glaucoma screening and preschool vision screening.

The newly established program will continue studies to determine the number, distribution, and nature of conditions leading to blindness, investigate further the causes of blindness in order to develop improved control procedures, and give consultation and assistance to local health departments and other agencies in their programs in sight conservation.

PROGRESS OF ALCOHOLISM RESEARCH AT UCLA CLINIC

The Alcoholism Research Clinic of the Department of Psychiatry of the University of California at Los Angeles, has been supported since September 1957 by the Division of Alcoholic Rehabilitation of the California State Department of Public Health.

The purpose of the UCLA Alcoholism Research Clinic is to study the problem of alcoholism in order to better understand the condition and find more effective methods of treating it.

The intent of the clinic is not solely treatment or service to patients but research and training of medical students, physicians, and others involved with the management of alcoholics.

Psychiatry recognizes alcoholism as a symptom of an underlying personality disorder. Although the excessive drinking may be controlled in certain instances, the psychiatric view is that the underlying personality disorder is usually left untouched. It is because of this view of physicians, particularly psychiatrists, that endeavors to understand alcoholism better and to improve treatment methods are undertaken in psychiatry.

The clinic staff consists of the director, three psychologists, a social worker, a statistician, clerical and research assistants, and a part-time volunteer staff of 10 physicians and other specialists.

Studies are being conducted in the areas of psychological testing, psychotherapeutic treatment methods, alcohol addiction, autonomic nervous system reactions, drug therapy, evaluation of Alcoholics Anonymous, group therapy with female alcoholics, and data collecting and analysis.

Psychological Testing

Measuring patient reactions with a battery of subjective and projective psychological tests has been a program function since the clinic was opened. The average testing caseload is 40 patients.

The tests thus far have indicated that, on the average, alcoholic patients display the same emotional complexes as those displayed by nonalcoholic psychiatric outpatients. The tests also have indicated that, on the average, the reactions of alcoholic patients to stimuli and perception tests are similar to those of nonalcoholic psychiatric outpatients.

Psychotherapeutic Treatment Methods

The clinic has experimented for more than two years with what the staff terms "process-oriented psychotherapy." The focus of treatment is on the total process of communication between the patient and the therapist.

The entire communicative behavior of the patient is examined during the treatment period. This means that the patient's nonverbal communication is as useful as his verbal communication, in contrast to other types of psychotherapy where it is assumed that nothing can be accomplished if the patient cannot communicate verbally.

This approach has been the subject of two papers by clinic staff members and has aroused some interest among psychiatrists in the community. It is only one of the psychotherapeutic techniques being studied in an effort to develop a variety of treatment methods which can help the alcoholic.

Alcohol Addiction

It has not been possible to establish experimentally a conclusive state of alcohol addiction in clinic laboratory animals, but a number of findings are of general interest. With rats, for instance, it is believed that hyperactivity, temporary loss of weight, muscle spasms and changes in brain activity accompany withdrawal of alcohol from the diet. These symptoms are akin to addiction in the sense of establishing a physiological need in the animals.

Work is also progressing in the field of behavioral addiction to alcohol in animals. Rats are being conditioned to drink alcohol to avoid disturbing stimuli; this is accomplished by alternating access to water and alcohol, with the choice of water accompanied by electric shocks or other physical irritants.

The byproducts of metabolism of alcohol in laboratory animals are being studied to determine what chemical in the process makes animals intoxicated. A few rats have shown, for example, that injections of alcohol plus pyruvate (a metabolic break-

down of alcohol) produces drunkenness faster than alcohol alone. This indicates that the metabolism of alcohol may be producing the behavioral manifestations of drunkenness and that this is causing a depressing action on the nervous system. The investigation is being broadened to study the direct effects of alcohol and its by-products on brain tissue by devising ways of injecting these substances directly into the brains of intact animals.

This technique also will be used to study changes in brain activity and behavioral manifestations produced by nutritional deficiencies, which sometimes result from long periods of alcohol intake. The purpose of these studies is to obtain evidence about possible organic and behavioral effects on the human brain of long-term nutritional deprivation, combined with chronic and excessive use of alcohol.

Autonomic Nervous System Reactions

A clinic laboratory was established in 1957 to record emotional responses controlled by the human autonomic nervous system.

During 1958 a series of studies was commenced, dealing principally with the effects of drugs on the autonomic nervous system. Present activities of the laboratory are directed toward understanding of emotional responsiveness. There are conflicting theories related to the effects of alcohol on the human nervous system. Data now being collected from social drinkers and alcoholics are expected to provide better factual information than now exists.

The major study has as its goal an answer to the question: "Does the ingestion of alcohol in moderate amounts lead to an increased or decreased emotional responsiveness?"

Drug Therapy

Drug testing and evaluation are major clinic activities, involving between 75 and 125 subjects each week. Many of the subjects are not regular clinic patients and are treated mostly at outside facilities.

Since alcoholics, regardless of therapy, are notorious for leaving treatment, the clinic drug study sample has been large enough to allow for a considerable dropout; the rate of this dropout is used in evaluating the effectiveness of a given drug. Patients are seen weekly (unless symptoms indicate a greater frequency) and treatment is prescribed by a physician trained in psychiatry and psychopharmacology. Several research technicians, skilled in administering questionnaires and in data handling, assist the physicians.

To date, more than two dozen drugs have been studied; literature on many more has been reviewed. Drugs that were studied were selected for their safety and promise of value in treating alcoholics. They can be classified into sedatives, tranquilizers, antidipsotrophics (Antabuse), antihistamines (Bristamin), steroids with tranquilizing action (Cetadiol), central nervous system stimulants or antidepressants (Deaner, Ritalin), and cerebral tonics (niacin).

None of the drugs tested so far has effectively decreased the incidence of drinking. Some apparently have improved the mood of the alcoholic, although there is no indication that this has been lasting or has improved his performance. Some of the more effective drugs for temporarily improving mood have been meprobamate, phenaglycodol (Ultran), and phenobarbital.

Placebos have also been effective. The clinic's studies show that 25 to 40 percent of the time the placebos (such as sugar pills) have improved the mood of the alcoholic. For this reason a drug is not considered effective unless it shows more improvement than does a placebo.

An interesting drug evaluation substudy is the use of LSD-25 (lysergic acid with diethylamine) with alcoholics. Some therapeutic success has been claimed in using LSD in mental illness, and it has been used widely in the study of brain chemistry and artificial psychosis.

LSD is more potent in effecting change in human consciousness than any other chemical known to man. The change in thought and feeling brought about by a small dose of LSD virtually defies verbal description. The drug produces profound individual reactions, depending on the physical and emotional condition of the subject, the dosage, and the conditions accompanying its use. The clinic has used LSD in an effort to learn whether it has therapeutic value, and if so, how it can be used in the treatment of alcoholism.

More than 100 subjects have received LSD, including alcoholics and social drinkers. The majority claimed beneficial aftereffects when they were contacted by means of a follow-up questionnaire six months or more after the experience. A number of the alcoholics reported that, at least temporarily, their frame of mind had been changed to the extent that they had lost a desire for alcohol.

Evaluation of Alcoholics Anonymous

An evaluation of Alcoholics Anonymous as a treatment method, started in 1956, has been broadened in the last two years to include psychological studies of individual members and the responses of recovered alcoholics to hallucinogenic drugs, such as LSD.

Group Therapy With Female Acoholics

Group therapy for women with drinking problems has been resumed at the clinic after a lapse of nearly a year. Past experiences, in which many of the women patients dropped out of treatment, led to reformulation of approach methods and some variations in therapy.

The new group is led by therapists who emphasize spontaneity and who exercise more control during the treatment periods. They have felt it necessary to prevent emotional outbursts as destructive to the newly forming relationships in the group. As a consequence, the therapists are looked upon as friendly but authoritative figures to whom it is easier for the patients to relate their feelings.

The results have been encouraging; patients are more responsible in attending meetings and have become a more cohesive group as the therapeutic relationships developed. Three all-women groups have been observed and some conclusions regarding the usefulness of this approach are being formulated.

Data Collecting and Analysis

The processing of data obtained from clinic psychological and drug studies is an immense task. In some of the research, setting up and conducting the studies requires less time and effort than processing the data which are the gross result.

Data from current drug studies and from psychological tests are now being processed by the IBM-709 computer, one of the most advanced machines of its type, which is located at the Western Data Processing Center on the UCLA campus. A full-time clinic statistician programs the data for the computers.

Dr. Merrill Assumes Presidency of APHA

Dr. Malcolm H. Merrill, State Director of Public Health, assumed the presidency of the American Public Health Association at the 1959 annual meeting of the association in Atlantic City, October 19-23. He was chosen president-elect at last year's annual meeting and automatically assumed the presidency in 1960. The annual meeting of the APHA will be held in San Francisco, so it will be particularly appropriate for Dr. Merrill to preside.

Dr. Merrill has long been active in the APHA, serving as chairman of various important committees, such as Research and Standards, Resolutions, and affiliated societies and regional branches.

California friends of Marian Sheahan, R.N., Deputy General Director of the National League for Nursing, will be interested to know that she was chosen president-elect of the APHA at the Atlantic City meeting and will assume the presidency at the close of Dr. Merrill's one-year term of office.

Among Californians elected to other offices in the various sections of the APHA are: A. Harry Bliss, Dr. P. H., Los Angeles, a three-year term on the Engineering and Sanitation Section Council; Arthur C. Hollister, Jr., M.D., Berkeley, Chairman of the Epidemiology Section; Ellis D. Sox, M.D., San Francisco, Vice Chairman of the Health Officers Section; Emil Palmquist, M.D., San Francisco, a two-year term on the Health Officers Section Council; Leslie Corsa, Jr., M.D., Berkeley, Chairman of the Maternal and Child Health Section; and William Griffiths, Ph.D., Berkeley, a three-year term on the Public Health Education Section Council.

High Tetanus Fatality Rate Shown In Six-Year Review

Of the 232 cases of tetanus reported during the last six years, 139 were fatal. Although tetanus occurs relatively infrequently, it continues to be a highly fatal disease. The cases of tetanus reported during the six-year period occurred in 30 of California's 58 counties. Two-thirds of the cases were in persons over the age of 20, although infants and children under the age of 10 were the victims in approximately one of five cases. Men were affected twice as often as women.

Seventy-eight percent of the cases occurred in connection with minor injuries. Sixty-three percent of the injuries which resulted in tetanus occurred in the home environment, and 17 percent at the place of employment. Ninety-one percent of the patients had not been immunized with tetanus toxoid or had not received a booster injection within five years of the onset of the disease.

The causative organism of tetanus is a natural inhabitant of the intestinal tract of man and animals, so perpetual reseeding of these organisms occurs in man's environment. Contamination of wounds makes everyone a candidate for the possible development of this disease.

Universal immunization with tetanus toxoid provides the potential means of protection. The occurrence of tetanus can be considered to be the result of what has been termed "unassimilated progress." An effective vaccine is available, but it has not been used on the broad scale desirable for protection of the civilian population. The armed services routinely protect their personnel by tetanus immunization.

Analysis of three criteria of growth, geographic expansion, annual expenditures, and number of full-time health department employees, leads to the conclusion that there has been no growth in local health departments since 1950.—Barkev S. Sanders, Ph.D., *Public Health Reports*, Vol. 74, No. 1.

Attorney General Opinions

A recent opinion of the Attorney General relates to death certificates. The County Counsel of Kern County asked this question of the Attorney General: "May a Christian Science practitioner attest the medical and health section data upon the death certificate prescribed by Section 10200, *et seq.* of the Health and Safety Code?"

The conclusion of the Attorney General's opinion is that "a Christian Science practitioner is not a 'physician' as that term is used in Section 10203 of the Health and Safety Code and therefore may not attest the medical data section of the death certificate." (Opinion No. 59-126.)

An even more recent opinion of the Attorney General was given in response to this question from Dr. Malcolm H. Merrill, State Director of Public Health: "Does the California Restaurant Act, Health and Safety Code Sections 28600 *et seq.*, apply to vehicles in which food, such as hot dogs and hamburgers, is cooked, prepared, and served to the public?"

The Attorney General concluded that such a vehicle is subject to the California Restaurant Act.

The opinion cited Section 28602 which includes in its definition of restaurant "any other eating or drinking establishment which sells or offers for sale food to the public." The opinion noted that "there is nothing in the definition that would make mobility a distinguishing feature."

The opinion also stated that "the Legislature has shown its intent to include vehicles in the definition of restaurants" by Section 28626 which expressly exempts vehicles from the provision of adequate and conveniently located toilet facilities. (Opinion No. 59-273.)

NEW FILM

The Pfizer Laboratories has announced release of a new film, *Physical Examination of the Newborn*, in which Mary Olney, M.D., of the University of California School of Medicine, demonstrates the techniques of physical examination to detect possible congenital anomaly or other condition.

The film is available to professional groups on request from Pfizer Medical Film Library, 267 West 25th Street, New York, New York.

Ann W. Haynes Honored By Prentiss Award

Ann W. Haynes, Chief of the Bureau of Health Education, California State Department of Public Health, has received the Cleveland Health Museum's 16th annual Elizabeth Severance Prentiss award for achievement in the field of health education.

The award was made at the recent annual meeting in Atlantic City of the American Public Health Association. Mrs. Haynes was cited for distinguished service to health education in recognition of her leadership in developing the state program in health education and in stimulating the health education programs in local California health departments.

Mrs. Haynes has also exercised leadership in her profession outside California. She has served as president of the Society of Public Health Educators, Chairman of the Public Health Section of the American Public Health Association, and President of the State and Territorial Directors of Health Education, and is a member of Delta Omega, public health honor society.

History of California Nursing Written by Rena Haig

Rena Haig, R.N., M.A., Chief of the Bureau of Public Health Nursing from its inception in 1937 until her retirement in 1957, has made use of retirement leisure by writing a short history of the development of public health nursing services in California under the State Department of Public Health.

Miss Haig traces the changes and slow growth in public health nursing services from 1913 through 1956.

The National League for Nursing has published this thoroughly documented account, since it is of interest not only in California but throughout the country.

The exact title is *The Department of Nursing Under the California State Department of Public Health — A Short History.* Copies are available at $1.25, postage included from the Department of Public Health Nursing, National League for Nursing, 10 Columbus Circle, New York 19, New York.

Medical Mission to Russia Reported by USPHS

The Report of the U. S. Public Health Mission to the Union of Soviet Socialist Republics—PHS publication 649—may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., at 45 cents a copy.

This report contains the findings of a mission of five doctors who visited the Soviet Union in 1957. [Dr. Merrill, State Director of Public Health, was a member of the mission.] They traveled 8,500 miles and visited 61 institutions in nine cities in five of the Soviet Republics. They found that the problem of medical care in the Soviet Union has been tackled with great vigor. There is a high ratio of physicians to total population, but the Soviet Government has deliberately focused on quantity and widespread coverage of personnel and services at the expense of quality. There are, however, certain ingredients in their political system which permit astonishingly rapid change-over and developments in medicine as impressive as the appearance of the first man-made earth satellite. Pestilential diseases and the diseases of filth have been substantially brought under control. Malaria as a significant health problem is on the way to eradication. Venereal disease has been mastered, but tuberculosis remains a plague.—*J.A.M.A., Vol. 170, No. 9, page 1093.*

New Zoonoses Center Opened In Argentina

The Pan American Sanitary Bureau, the world's oldest international health organization, has inaugurated a Pan American Zoonoses Center in Azul, Argentina. The center is dedicated to the study of diseases transmitted between animals and man.

Recognition of the drain on health and economy of the hemisphere from these diseases led to the agreement between the Argentine Government and the Pan American Health Organization for establishment of the center.

The Rockefeller Foundation has made a grant of $10,000 to the PASB for financing a study of the zoonoses problem in the Americas.

Medical Co-ordinator Appointed For Region III

Byron O. Morck, M.D., M.P.H., has taken the position of Medical Co-ordinator for Region III, Southern California.

Dr. Morck's appointment fills the last of three positions created by the new organizational structure of the State Department of Public Health. The other two Regional Medical Coordinators are C. Henry Murphy, M.D., M.P.H., Region I, which includes the Bay area and the northern and coastal counties, and Hamlet C. Pulley, M.D., M.P.H., Region II, which includes the valley counties.

Dr. Pulley Dr. Murphy Dr. Morck

Dr. Morck comes to the State Health Department with a wealth of public experience, plus an intimate knowledge of the area of assignment. He was a district health officer in the Los Angeles City Health Department for five years and a school physician with the Los Angeles City Schools for a year. Since 1951, Dr. Morck has been a lecturer in public health and associate professor of preventive medicine and public health at the University of California in Los Angeles. For the last three years he has been the Pasadena District Medical Consultant for the Vocational Rehabilitation Service of the State Department of Education.

Dr. Morck received his medical degree from the University of Minnesota Medical School in 1931 and practiced medicine for 17 years before serving two years as district health officer for the Minnesota State Health Department.

In 1950 Dr. Morck obtained a master's degree in public health from the University of Minnesota. He is also a Diplomate of the American Board of Preventive Medicine.

Aspirin topped the list (25%) of 4,000 accidental poisoning cases transmitted to National Clearing House of Poison Control Center. All told, 90% of cases involved children.—*A.M.A. News,* Vol. 2, No. 13.

PUBLIC HEALTH POSITIONS

Alameda County

A number of positions are open in one of California's largest health departments. This is a consolidated, city-county department, across the bay from San Francisco, covering both urban and rural areas.

Assistant Health Officer: Salary range, $1,048 to $1,155. To direct the operations of a major program or geographic area. Requires California medical license plus three years public health medical experience, or two years experience and an MPH.

Public Health Medical Officers: Salary range, $905 to $998. To direct administrative unit in the health department. California medical license required, plus one year public health medical experience or one year graduate training in public health.

Chief Health Educator: Salary range, $556 to $676. Requires MPH plus three years of progressively responsible health education experience. Opportunity for close affiliation with School of Public Health, University of California, Berkeley.

Public Health Nurse: Salary range, $458 to $530. Generalized program including some home nursing and school nursing. Requires California PHN registration.

Sanitarian: Salary range, $458 to $530. Generalized sanitation program. California certification required.

Dental Hygienist: Salary range, $415 to $505. Requires California registration plus one year in school or health department program.

Physical Therapist: $415 to $505. To work in cerebral palsy program. California registration is required, plus one year's experience.

For further information about any of these positions, contact Mr. I. Schnayer, Alameda County Civil Service, 188 12th Street, Oakland, California, HI gate 4-0844.

Public Health Social Worker: Salary range, $481 to $584. To carry administrative and consultative responsibilities for social work services throughout the health department. Requires a master's degree in social work, plus three year's work experience, one of which was in public health.

California State

Public Health Nurse: Salary range, $458 to $556. Employment is with the State Department of Public Health for assignment to a rural county which has contracted with the State for public health services. Vacancies now in Mother Lode, Lake Tahoe, and Trinity recreational areas. Transportation furnished; liberal personnel benefits. Opportunities for progressive program development in rural communities.

Requirements include completion of an educational program which is approved by the National League for Nursing, and possession of a valid certificate as a public health nurse in California. Applicant must have had two years of experience within the last 10 years as a PHN in a generalized public health nursing program.

For application forms and further information write to Miss Corrine Hall, Public Health Nursing Supervisor, Bureau of Contract Services, California State Department of Public Health, 2151 Berkeley Way, Berkeley, California.

Humboldt-Del Norte County

Public Health Nurse: Salary range, $439 to $549, with advance to second step after six months. County car furnished. Generalized program, including school nursing. Requires California PHN certificate.

Sanitarian: Salary range, $439 to $549, with advance to second step after six months. County car furnished. Generalized program. Requires California certification, preferably with one year's experience in a local health department.

Contact L. S. McLean, M.D., Health Officer, Humboldt-Del Norte County Department of Public Health, P. O. Box 857, Eureka, California.

Imperial County

Public Health Officer: Salary range, $940 to $1,170. To plan and direct the public health program for the county. New health center to be constructed during next year. Requires a California medical license and experience in public health administration. Contact Administrative Assistant, Courthouse, El Centro, California.

Kings County

Director of Public Health: Salary range, $849 to $1,017. To be directly responsible to the board of supervisors for the operation of a staff of 24 to serve the county's population of 50,000. Requires at least three years experience; valid license to practice medicine in California; MPH preferred, but not mandatory. Provides vacation, sick leave, and retirement plan. No age limit has been set. Apply, giving qualifications, to Board of Supervisors, Box 707, Hanford, California.

Napa County

Public Health Nurse: Salary range, $376 to $458. Generalized program, 50 miles from San Francisco. Starting salary depends on qualifications. Automobile required; car allowance provided. Contact Sterling S. Cook, M.D., Director of Public Health, P. O. Box 749, Napa, California.

San Luis Obispo County

Public Health Medical Officer: Salary range, $800-$957. California medical license and one year of experienec in public health maternal and child health program or equivalent. Early opportunity for advancement to County Health Officer if qualified. Examination by interview only. Salary open to negotiation based on qualifications.

Microbiologist: Salary range, $382-$460. California certificate as Public Health Microbiologist required.

For further information write to San Luis Obispo County Civil Service Commission, 967 Osos Street, San Luis Obispo, California.

Despite nationwide publicity about the dangers of plastic garment bags, AMA's Committee on Toxicology has learned that bags embossed with an almost life-sized Santa Claus are being offered the Christmas trade.—*AMA News,* October 5, 1959.

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